AOPA In Advance SmartBrief
Breaking News
November 2, 2017

AOPA Headlines:

CMS Publishes Proposed Rule That Would Provide States with Flexibility in Defining Essential Health Benefits

On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the *Federal Register* entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019." Among the provisions in the proposed rule is a section that would provide individual states with increased flexibility in defining essential health benefits (EHB) for purposes of establishing benchmark plans required by the Affordable Care Act.

The proposed rule introduces a new regulation that would allow individual states to either (a) select the EHB-benchmark plan of another state as its own; (b) replace one or more EHB categories of benefits in its EHB-benchmark plan with the same categories of benefits from another state's EHB-benchmark plan; or (c) otherwise select a set of benefits that would become the EHB-benchmark plan so long as the benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans.

AOPA is currently reviewing the 365 page proposed rule but is obviously concerned about the potential impact on beneficiaries of any relaxation of the regulations requiring coverage of essential health benefits, including orthotics and prosthetics. AOPA will be providing comments on the proposed rule by CMS prior to the November 27, 2017 deadline.

The proposed rule may be accessed by clicking here.

Questions regarding this issue may be directed to Joe McTernan at (571) 431-0811 or Devon Bernard at (571) 431-0854.

Take Action Now to Stop the Department of Veterans Affairs from Limiting Your Veteran Patients' Right to Choose

The October 16, 2017 *Federal Register* included a proposed rule published by the Department of Veterans Affairs (VA) that intends to "reorganize and update the current regulations related to prosthetic and rehabilitative items, primarily to clarify eligibility for prosthetic and other rehabilitative items and services, and to define the types of items and services available to eligible veterans."

There is a provision in the proposed rule that significantly threatens longstanding VA policy that allows the veteran to decide whether they receive O&P services directly from the VA or from a VA contracted provider. This provision requires an immediate and powerful response. The proposed language states the following:

"VA will determine whether VA or a VA-authorized vendor will furnish authorized items and services under § 17.3230 to eligible veterans. When VA has the capacity or inventory, VA directly provides items and services to veterans. However, VA also may use, on a case-by case basis, VA authorized vendors to provide greater access, lower cost, and/or a wider range of items and services. We would clarify in regulation that this administrative business decision is made solely by VA to eliminate any possible confusion as to whether a veteran has a right to request items or services generally, or to request specific items or services from a provider other than VA, and to clarify for the benefit of VA-authorized vendors that VA retains this discretion as part of our duty to administer this program in a legally sufficient, fiscally responsible manner."

This language, if finalized, is in direct conflict with the current VA policy as well as the Veteran's Access, Choice, and Accountability Act of 2014 and will significantly restrict the ability of a veteran to see the VA contracted provider of their choice for prosthetic and orthotic care.

AOPA has established a convenient pathway that will allow you to quickly express your concern regarding the VA proposed rule. Simply visit www.AOPAVotes.org, enter some basic information, and a customized letter will be generated and sent to the VA to express your concern over the unnecessary and unreasonable provisions of the proposed rule. **Send comments now.**

Agency for Healthcare Research and Quality Releases a Draft Systematic Review of Lower Limb Prostheses Research

The Agency for Healthcare Quality Research (AHRQ), in conjunction with a contractor known as an Evidence-based Practice Center, has released a draft systematic review of current scientific literature that address the use of lower limb prostheses in the United States. The Systematic review was originally announced in September of 2016 with a request for additional comments on the "key questions" that would be used in the systematic review in December of 2016. AOPA

provided significant comments on the systematic review itself as well as on the key questions issue.

While the complete systematic review document is 440 pages and is currently under review by AOPA, the abstract of the systematic review indicates the following:

- 92 studies were identified that assessed performance characteristics of lower limb prostheses
- 29 of the 92 studies were deemed valid and reliable by the researchers
- 19 of the 29 studies were generally applicable to Medicare aged populations
- 11-22% of amputees abandon their lower limb prosthesis within one year of delivery
- Unilateral trans-femoral amputees are twice as likely to abandon their prosthesis than unilateral trans-tibial amputees
- Currently, there is no evidence to support the selection of specific components for patient subgroups to maximize ambulation, function, and quality of life or to minimize abandonment or limited use

While AOPA supports the need to review the current research that addresses lower limb prostheses, we do not agree with much in the conclusions, and particularly its final abstract conclusion noted above, as there is **clear** evidence, apparently not considered by AHRQ or its contractor to support specific components for patient subgroups for maximizing favorable patient outcomes. It is important to recognize that the draft systematic review did not include recent research by the RAND Corporation and the health economics firm Dobson DaVanzo that specifically studied both the clinical and cost effectiveness of the provision of higher technology prosthetic limbs, despite AOPA's having submitted BOTH preliminary findings of both studies before the December, 2016 AHRQ deadline, as well as the final study results of both being submitted to AHRQ as soon as the first became available seven (7) weeks ago. It is particularly unfortunate to see a purportedly current literature review be deficient in not reflecting the latest determinative scientific findings.

AOPA will be preparing extensive comments on the draft systematic review and encourages its members to review the document and provide comments as appropriate. The draft Systematic Review document may be viewed by clicking here.

AOPA Holds Press Event on the "Amputee Tech Gap"

On October 19, AOPA hosted a press event at the National Press Club in Washington DC, to share the important research from the RAND Corporation on the economic value of advanced prosthetics.

Dr. Soren Mattke from RAND presented the findings of this recently published research that concluded that microprocessor knees are associated with improvements in physical function and reductions in falls and osteoarthritis, and that the economic benefits are in line with commonly accepted criteria for good value for money by U.S. payers.

Dr. Ken Kaufman, PhD of the Mayo Clinic, shared his research on health outcomes for those living with limb loss, including the cost of care broken down by K-level, and the costs of falls, and the large number of amputees who never receive a prescription for a prosthesis. Prosthetic users Christopher Allen and Peggy Chenoweth discussed how they have benefited from advanced technology in their everyday lives.

The video was livestreamed on Facebook and is now available to view. The Power Point presentations used are available upon request.

About the RAND Corporation study

Due to recent advances in technologies, prosthetic knees allow for more-dynamic movements and improve user quality of life, but payers question their value for money. To explore this issue, RAND simulated the differential clinical outcomes and costs of microprocessor-controlled knees (MPKs) compared with non-MPKs (NMPKs). They conducted a literature review of the clinical and economic impacts of prosthetic knees, convened technical expert panel meetings, and implemented a simulation model over a ten-year time period for unilateral transfemoral Medicare amputees with Medicare Functional Classification Levels of 3 and 4.

They found that compared with NMPKs, MPKs are associated with sizeable improvements in physical function and reductions in incidences of falls and osteoarthritis. The simulation results show that over a ten-year time period, compared with NMPKs, MPKs are associated with an incremental cost of $10,604 per person and an increase of 0.91 quality-adjusted life years per person, resulting in an incremental cost of $11,606 per quality-adjusted life year gained. The results suggest that the economic benefits of MPKs are in line with commonly accepted criteria for good value for money and with those of other medical devices that are currently covered by U.S. payers.
Read the RAND Study.

This study is just part of AOPA's commitment to advancing O&P research. See all of AOPA's Research Initiatives.

Press about the Event so far:
O&P Edge– RAND Study: Far Fewer Falls With MPKS
Medscape– Modern Prosthetic Knees Cut Falls, Morbidity, Mortality in Amputees (login required)
Rehab Management – Amputees Are Being Denied Access to Higher-Tech Prostheses, Resulting in Preventable Injury and Death, Per RAND Study

Short-Term Health Insurance, End of Subsidies Paid to Health Insurers—What Does It Mean to You and Your Patients?

On October 12, President Trump undertook a non-legislative overhaul of the country's healthcare insurance program, and some significant administrative 'repeal' of the Affordable Care Act. Two major executive actions comprise this effort:

(1) clearing the path for sale of "short-term" insurance plans that do not have full ACA essential health benefits and other rules, at lower rates for healthy individuals, as well as clearing the path for sale of insurance through 'association plans' that will include sale of insurance across rate lines without meeting state license laws (parity laws from one state may not apply to plans sold by an out-of-state carrier who operates in a state that does not have parity rules). At peak, there were only about 100,000 Americans enrolled in these short-term plans, so immediate effect will probably not be dramatic. That said, this does initiate a segmenting of the market, incentivizing some healthy persons not to participate in the state-level insurance exchanges under ACA, but to gravitate to these cheaper, less robust short-term plans. If this snowballed to having much larger number of people in short-term plans it would tend to shift the risk pool in the exchanges in the direction of the unhealthier Americans, likely de facto giving them some characteristics of higher risk pools. Indirectly, persons with pre-existing conditions could find themselves relegated to the exchanges and their insurance rates would probably increase across the board without the balance of exchange participation by healthier individuals.

(2) The administration will stop providing the $7 billion in annual, so-called CSR subsidies to health insurers to help cover the co-pays and deductibles of lower income individuals. This is facilitated because of legal challenges where one federal district court deemed these subsidies illegal. Ending the subsidies creates some hard decisions for insurers. They may: (1) continue the credits for co-pays/deductibles without collecting any off-setting subsidy payments which would result in little change in policyholder experience in the short run (some insurers already issued major hikes in 2018 rates, likely anticipating that the subsidy payments would end); (2) thirty-two states will allow insurers to levy a surcharge to offset the loss of subsidies and thereby increasing the premiums (low cost insureds will be eligible for larger tax credits essentially offsetting these larger premiums so they won't have too much pressing them to drop coverage), or (3) with subsidies unavailable, insurers are permitted to withdraw from the 2018 ACA insurance exchanges in each state over the next few weeks before annual enrollment in the ACA plans begins.

There is a timing disconnect. It will take a substantial amount of time for folks at HHS and CMS to write and implement the many new rules that will be needed to effectuate the short-term plans and association plans. So, these short-term plans will probably not be available for months or perhaps up to a year, even as the subsidy situation could push many folks from their current plans. Providers will want to take more special care that patients are enrolled and paid in their plans before delivering care. It's important to recognize that, at least in the near term, these changes will impact only a portion of the health insurance market. In the short term; employer-based plans, Medicare, Medicaid, and VA, will remain unaffected—though in the longer term the premiums for these plans may change.

There are likely to be lawsuits challenging both of these steps. Both hospitals and health insurers will oppose these steps—hospitals because it will shift many more uninsured folks into emergency rooms, and increase uncompensated care (the expense of which falls on the hospitals), and insurers because, obviously, they want the subsidies. Look for attempts at legislation to stabilize insurance premiums.

Clearly, a time of change has been initiated that will impact providers over coming months. Depending on how health insurers respond, the results could have our health care looking more like it did before the ACA was enacted: more lower income people uninsured; sicker people potentially paying higher premiums, no assured universal essential health benefits, more people

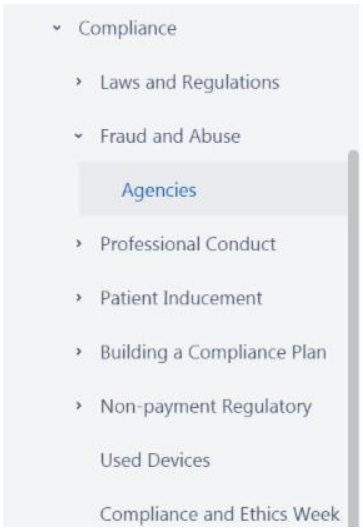
seeking care in hospital emergency rooms listed as uncompensated care, but actually with the cost of their coverage subsidized by higher costs for paying patients and cost-shifting. Can the President do this on his own? We will need to wait through a few years and watch the results on a likely bevy of litigation that will begin to unfold. One enduring fact will be that so long as the Affordable Care Act remains the law, any executive actions taken and regulations enacted by one President will be subject to the prospect of complete reversal by another President. We'll continue to keep AOPA members informed of significant developments.

The AOPA Co-OP and Compliance

What compliance resources are in the AOPA Co-OP?

- Laws and Regulations
- Medicare Program Integrity Manual
- Medicare Claims Processing Manual
- Gifts to Patient
- Building a Compliance Plan
- Medical Device Excise Tax
- Much more, plus billing, state, and other resources

Like a Wikipedia of all things Compliance (and reimbursement, coding and policy), the Co-OP is your one stop shop! Take advantage of this new AOPA member benefit now. Sign up for the Co-OP.



Use the Co-Op for all things Compliance and find more resources on AOPA's Healthcare Compliance & Ethics Week page.

Celebrate Healthcare Compliance & Ethics Week Nov 5-11, 2017 Access more resources on www.AOPAnet.org.

Promote your Brand with AOPA's new Apparel Program

AOPA is partnering with Encompass Group, a leading provider of health care apparel to offer members special prices on customized polos, scrub tops and lab coats. Customized embroidery is available.

For more information on products and available colors, go to www.iconscrubs.com. Enter access code: ICON-AOPA. Then enter your AOPA member id, and create your user profile.

Contact bleppin@AOPAnet.org for additional information or call 571-431-0810.

Upcoming AOPA Events

November 6-7, 2017	*Coding & Billing Seminar* Phoenix, AZ Learn more and register here
November 8, 2017	*Gift Giving: Show Your Thanks & Remain Compliant* AOPA Webinar Learn more and register here
Save the date: January 5-7, 2018	AOPA Leadership Conference (Invitation Only) Palm Beach, FL